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	17E038	A. BUILDING _____ B. WING _____	02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVILAND CARE CENTER LLC	200 MAIN HAVILAND, KS 67059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and complaint investigation #KS00080299.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility had a total census of 40 residents. Based on observation, record review and interview, the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 9 of 30 resident rooms and the beauty shop/quiet room.. Findings included: - During environmental tour beginning on 1/26/15 at 7:15 AM, the following maintenance issues were observed in 9 of 30 resident rooms and the beauty shop/quiet room. * chipped paint with rusted metal exposed on the lowest 2 to 3 inches of the bathroom door frames in 6 rooms * rusted caulking surrounding the base of the toilet between the toilet bowl and the floor in 3 bathrooms * heating/air conditioning units with no top grill	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 253	Continued From page 1 covering in 2 rooms * the bottom wall trim was missing in 2 rooms with short 3 inch x 4 inch corner pieces and crumbled dirty plaster observed in 1 room * a strip of wall trim approximately 2 -3 feet x 4 inches long missing along the bottom of one wall and approximately 1 foot x 4 inches on the adjacent wall in the beauty shop/quiet room multiple areas large and small were previously patched without matching paint on the surfaces in all 9 rooms During an environmental tour and interview on 2/3/15 at 9:02 AM maintenance staff C and Administrative staff A reported the facility made improvements in the environment over the last year with some of the repairs being more recent in the last month. Staff C he/she had a new system in place for routine monthly inspections of the facility and resident rooms. Staff C provided 2 worksheets which included the resident's room numbers, and the type of repair needed. Staff C reported he/she just implemented the program a short time ago and could not provide any further documentation the rooms were being inspected and repairs completed on a regularly scheduled maintenance program. The facility's maintenance service policy revised in December 2009 revealed the maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained. The maintenance director is responsible for maintaining records for the following including inspection of the building,	F 253		

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F 253	Continued From page 2 work order requests, and maintenance schedules. The facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 9 of 30 resident rooms and the beauty shop/quiet room.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility census totaled 46 residents with 12 included in the sample. Based on observation, interview, and record review, the facility failed to conduct a significant change assessment for resident #25 after he/she returned from the behavioral unit on 12/30/14 and required hospitalization on 1/10/15 for dehydration and hypokalemia (low potassium in the blood), and declined in the resident's physical and mental condition. (#25)	F 274		

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F 274	Continued From page 3	F 274		

Findings included:

- Review of resident #25's annual MDS (minimum date set) dated 10/13/14 revealed the resident had a BIMS (brief interview for mental status) score of 15 indicating the resident was cognitively intact. The resident required supervision for bed mobility, transfers, locomotion on the unit, dressing and toilet use and did not use any mobility devices. The resident was always continent of bowel and bladder.

Review of the ADL (activities of daily living) CAA (care area assessment) dated 10/13/14 revealed the resident was at risk for potential self-care deficit due to requiring prompting to complete his/her ADLs The care plan instructed staff to encourage the resident to complete ADLs independently and assist the resident as needed. The care plan also directed staff to document when the resident completed ADLs and the amount of assistance needed.

Review of the Quarterly MDS dated 1/13/14 revealed the resident had a BIMS score of 14 indicating the resident was cognitively intact. The resident required supervision with one assist for bed mobility, transfers, walk in room, locomotion on unit, toilet use, and personal hygiene and required the use of a walker for mobility. The resident was frequently incontinent of bowel and always continent of bladder. The MDS also indicated the resident was dehydrated. The facility failed to capture resident #25 decline in bowel incontinence, new diagnosis for dehydration and hypokalemia, ADL decline requiring assistance from one staff, and the use of a walker for ambulation.

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Review of the 12/9/14 revised care plan revealed staff failed to update the care plan after returning from the behavioral unit on 12/30/14, with diarrhea starting on 1/1/15, and a hospitalization for dehydration and hypokalemia (low potassium in the blood) from 1/10/15 to 1/13/15.

According to the nurse's notes, fluid intake monitoring, bowel and bladder monitoring, physician notes, and review of the history and physical from the behavioral unit and local hospital, resident #25 required hospitalization for treatment of dehydration and hypokalemia (low potassium in in the blood). The facility failed to revise or update the resident nursing care plan after the hospitalizations to prevent and maintain adequate hydration for the resident.

An observation on 1/29/15 at 2:55 p.m. revealed the resident was lying down on his/her bed on the left side, resting. The resident showed no signs of distress or dehydration. His/her legs appeared to be swollen around the ankles and up to his/her calf area.

An interview on 2/2/15 at 9:13 a.m. with direct care staff E revealed the resident returned from the behavioral unit in December of 2014 and he/she came back confused, incontinent, and using a walker. He/she also returned with diarrhea. The resident required assistance with his/her ADLs. The resident then went to local hospital for low potassium and dehydration. The diarrhea has continued for an extended period of time.

An interview on 2/2/15 at 3:27 p.m. with direct care staff F revealed the resident used the walker

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for ambulation along with cueing after his/her return from the behavioral unit in December. The resident was admitted to the local hospital for an electrolyte problem in January.

Interview on 2/3/15 at 8:31 a.m. with licensed nursing staff J He/she also reported the resident came back to the facility with a decline in ADLs requiring some assistance, required the use of a walker to ambulate, and had diarrhea. The resident was admitted to the local hospital on 1/10/15 and returned to the facility on 1/13/15 with a new diagnosis of dehydration, hypokalemia, and new diarrhea medications. Nurse J revealed he/she did not update or revise the care plan after the resident returned either time to the facility and he/she did not complete a comprehensive significant change assessment for the resident after the change in the resident's condition in 2 or more areas.

Interview on 2/2/15 at 6:04 p.m. with administrative nurse B revealed Nurse B also reported the facility failed to update or revise the care plan after the resident came back from the behavioral unit or the local hospital. Nurse B reported a comprehensive significant change assessment for resident #25 should have been conducted when he/she came back from the behavioral unit and from the hospital.

The facility failed to conduct a comprehensive significant change assessment for resident #25 after he/she returned from the behavioral unit on 12/30/14 and required hospitalization on 1/10/15 for dehydration and hypokalemia (low potassium in the blood), and declined in physical and mental condition. (#25)

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F 280	Continued From page 6	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 46 residents with 12 included in the sample. Based on observation, interview, and record review, the facility failed to review and revise resident #25's nursing care plan after he/she returned from the behavioral unit on 12/30/14 and required hospitalization on 1/10/15 for dehydration and hypokalemia (low potassium in the blood). (#25)

Findings included:

- Review of resident #25's annual MDS

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(minimum date set) dated 10/13/14 revealed the resident had a BIMS (brief interview for mental status) score of 15 indicating the resident was cognitively intact. The resident required supervision for bed mobility, transfers, locomotion on the unit, dressing and toilet use and did not use any mobility devices. The resident was always continent of bowel and bladder.

Review of the ADL (activities of daily living) CAA (care area assessment) dated 10/13/14 revealed the resident was at risk for potential self-care deficit due to requiring prompting to complete his/her ADLs The care plan instructed staff to encourage the resident to complete ADLs independently and assist the resident as needed. The care plan also directed staff to document when the resident completed ADLs and the amount of assistance needed.

Review of the Quarterly MDS dated 1/13/14 revealed the resident had a BIMS score of 14 indicating the resident was cognitively intact. The resident required supervision with one assist for bed mobility, transfers, walk in room, locomotion on unit, toilet use, and personal hygiene and required the use of a walker for mobility. The resident was frequently incontinent of bowel and always continent of bladder. The MDS also indicated the resident was dehydrated.

Review of the 12/9/14 revised care plan revealed staff failed to update the care plan after returning from the behavioral unit on 12/30/14, with diarrhea starting on 1/1/15, and a hospitalization for dehydration and hypokalemia (low potassium in the blood) from 1/10/15 to 1/13/15.

According to the nurse's notes, fluid intake

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monitoring, bowel and bladder monitoring, physician notes, and review of the history and physical from the behavioral unit and local hospital, resident #25 required hospitalization for treatment of dehydration and hypokalemia (low potassium in in the blood). The facility failed to revise or update the resident nursing care plan after the hospitalizations to prevent and maintain adequate hydration for the resident.

An observation on 1/29/15 at 2:55 p.m. revealed the resident was lying down on his/her bed on the left side, resting. The resident showed no signs of distress or dehydration. His/her legs appeared to be swollen around the ankles and up to his/her calf area.

An interview on 1/29/15 at 2:53 p.m. with resident #25 revealed he/she continued to have loose stools. He/she reported the night nurse assisted him/her when he/she was unable to make it to the bathroom on time. Resident #25 revealed he/she continued to be worried about why he/she continued to have the diarrhea.

An interview on 2/2/15 at 9:13 a.m. with direct care staff E revealed the resident returned from the behavioral unit in December of 2014 and he/she came back confused, incontinent, and using a walker. He/she also returned with diarrhea. The resident required assistance with his/her ADLs. The resident then went to local hospital for low potassium and dehydration. The diarrhea has continued for an extended period of time.

An interview on 2/2/15 at 3:27 p.m. with direct care staff F revealed the resident used the walker for ambulation along with cueing after his/her

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return from the behavioral unit in December. The resident was admitted to the local hospital for an electrolyte problem in January. He/she also reported the resident had become lethargic and was falling. Staff F reported unless the resident used the call light staff was unaware of when or how much diarrhea the resident had due to being independent with toileting. Direct care staff F reported the only monitoring of hydration for the resident was at meal and snack times. He/she also reported the staff did not monitor the output for the resident.

Interview on 2/3/15 at 8:31 a.m. with licensed nursing staff J revealed staff was instructed to assess and monitor the resident daily on all shifts after his/her return from the behavioral unit on 12/30/14. He/she also reported the resident came back to the facility with a decline in ADLs requiring some assistance, required the use of a walker to ambulate, and had diarrhea. The resident was admitted to the local hospital on 1/10/15 and returned to the facility on 1/13/15 with a new diagnosis of dehydration, hypokalemia, and new diarrhea medications. Nurse J revealed he/she did not update or revise the care plan after the resident returned either time from the facility.

Interview on 2/2/15 at 6:04 p.m. with administrative nurse B revealed nursing staff failed to monitor and assess the resident daily for signs and symptoms of dehydration. Nurse B also reported the facility failed to recognize the resident was at risk for dehydration after returning from the behavioral unit with the diarrhea first started. Nurse B also reported the facility failed to update or revise the care plan after the resident came back from the behavioral unit or

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F 280	Continued From page 10 the local hospital. Interview on 2/3/15 at 9:55 a.m. with physician D revealed the resident started the diarrhea when returning to the facility from the behavioral unit. He/she reported the resident became dehydrated, had a low potassium level, and needed to be admitted to the hospital. He/she reported they expected the facility to be monitoring accurately the resident's fluid intake and output, along with daily assessments after returning with the new diagnoses for dehydration. He/she also expected the care plan to be updated and followed. Review of the facility policy on care plan dated 6/2013 revealed the facility will review and revise the resident's care plan after the resident assessment or assessment review. The facility failed to review and revise resident #25's nursing care plan after he/she returned from the behavioral unit on 12/30/14 and required hospitalization on 1/10/15 for dehydration and hypokalemia (low potassium in the blood). (#25)	F 280		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: The facility census totaled 46 with 12 included in the sample. Based on observation, interview, and record review, the facility failed to provide sufficient fluids to maintain adequate hydration for	F 327		

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1 of 2 residents reviewed for hydration. Resident #25 required hospitalization for treatment of dehydration and hypokalemia (low potassium in the blood) after he/she had severe diarrhea from several days.

Findings included:

- Review of resident #25's annual MDS (minimum data set) dated 10/13/14 revealed the resident had a BIMS (brief interview for mental status) score of 15 indicating the resident was cognitively intact. The resident required supervision for bed mobility, transfers, locomotion on the unit, dressing and toilet use and did not use any mobility devices. The resident was always continent of bowel and bladder.

Review of the ADL (activities of daily living) CAA (care area assessment) dated 10/13/14 revealed the resident was at risk for potential self-care deficit due to requiring prompting to complete his/her ADLs The care plan instructed staff to encourage the resident to complete ADLs independently and assist the resident as needed. The care plan also directed staff to document when the resident completed ADLs and the amount of assistance needed.

Review of the Quarterly MDS dated 1/13/15 revealed the resident had a BIMS score of 14 indicating the resident was cognitively intact. The resident required supervision with one assist for bed mobility, transfers, walk in room, locomotion on unit, toilet use, and personal hygiene and required the use of a walker for mobility. The resident was frequently incontinent of bowel and always continent of bladder. The MDS also indicated the resident was dehydrated.

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Review of the 12/9/14 care plan revealed staff failed to update the care plan after returning the resident had diarrhea starting on 1/1/15, and failed to add interventions to address the diagnoses of dehydration and hypokalemia (low potassium in the blood).

The resident admitted to a hospital from 12/11/14 to 12/30/14 for unrelated issues.

Review of the lab values at the hospital dated 12/24/14 revealed the resident had a normal potassium serum level of 3.8 mmol/L (the measurement unit used for indicating the concentration in the blood), and normal potassium level is between 3.5 - 5.1 mmol/L.

Review of the patient transfer form from the hospital revealed the resident was concerned about his/her bowels.

Review of the telephone order dated 12/30/15 revealed the resident readmitted to the facility. The resident may use the walker for stability and labs were to be drawn weekly for 6 months.

Review of the nursing note dated 1/1/15 at 3:22 p.m. revealed the resident stayed in his/her room all shift. His/her temperature was down to 98.3 degrees Fahrenheit. The resident didn't have any more episodes of diarrhea. The facility failed to document and to monitor the resident's temperatures.

Review of the nursing note dated 1/2/15 at 10:42 a.m. revealed the facility notified consultant physician D regarding the resident's loose stools. He/she ordered to continue to isolate the resident

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and to treat with symptomatic care.

Nursing note dated 1/2/15 at 2:15 p.m. revealed the resident had numerous loose stools this shift.

Review of the nursing note dated 1/3/15 at 11:48 p.m. revealed the resident had 4 loose stools this shift. Upon arriving on the shift the nurse took the resident's vital signs which revealed the resident's oxygen level was at 85% and 86% on room air (normal oxygen level on room air is above 90%). The resident was lethargic (sluggish), incontinent, and was drooling on his/her chest. The nurse notified the on call physician, who recommended the resident to be seen in the emergency room. The resident was taken to the local hospital where later returned due to his/her oxygen level was above 90% and within normal limits. The resident had a loose bowel movement in his/her brief and staff administered Imodium (medication for diarrhea) was administered per the physician orders. The Imodium was given one time dose.

Review of nursing note dated 1/4/15 at 8:04 a.m. the nursing staff administered Imodium per physician orders. Direct care staff assisted the resident to sit up and take the medication. Nursing staff also assisted with eating the breakfast meal of scrambled eggs, toast, and 8 ounces of Gatorade. The resident appeared to be very weak and lethargic.

Review of the untimed nursing note dated 1/4/15 revealed the resident continued to have very loose stools and was very lethargic. The resident required assistance with his/her evening meal. The vitals were taken and revealed a blood pressure of 85/55 (a low blood pressure for the resident), temperature of 96.7, pulse of 81,

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respirations of 18, and oxygen level of 97% on room air.

Review of fax cover sheet dated 1/4/15 revealed the resident was seen the emergency room on 1/3/15 for diarrhea and lethargy. Physician D decreased Xanax (a medication for anxiety) from 1 mg (milligram) four times a day to 0.5 mg four times a day for lethargy and continue to monitor.

Review of the nursing note dated 1/5/15 at 2:32 a.m. revealed the resident was very drowsy and did not want to do his/her own ADLs. The resident was sick with intestinal problems.

Review of the nursing note dated 1/5/15 at 4:31 a.m. revealed the resident used the call light and was found in the bathroom. His/her brief was on the floor full of feces. The resident also urinated all over the floor by the bed. The resident's speech was hard to understand and he/she had trouble walking with the walker.

Review of the Bladder retraining recorded dated between 1/6/15 and 1/9/15 revealed the resident had 12 episodes of bowel incontinence along with several hours of undocumented bowel and bladder record.

Review of Physician signed note dated 1/8/15 revealed the resident had 1 dose of Imodium on 1/7/15 and the resident's abdomen had hyperactive bowel sounds.

Review of the nursing note dated 1/9/14 revealed the resident had 4 loose stools at the local hospital while doing lab tests.

Review of nursing note dated 1/10/15 at 2:18

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p.m. revealed the resident left the facility at 9:00 a.m. for lab at the hospital. The resident admitted to the hospital for fluids and potassium replacement with a critical low potassium level of 2.5 mmol/L. (Because fat tissue contains less water than lean tissue, the total amount of water in the body tends to decrease with age. The common cause of dehydration is diarrhea and vomiting resulting in a loss of electrolytes (especially sodium and potassium), even more water is lost, so the concentration of sodium in the blood rises.

Review of the hospital History and Physical dated 1/10/15 revealed the resident had severe diarrhea for the past 12 days. He/she had labs drawn and revealed to have significantly low potassium of 2.4mmol/L and a normal potassium level was between 3.4 -5.3 mmol/L. According to the History and Physical, the resident went to the emergency room on 1/3/15 with instructions to take Imodium with minimal improvements.

Review of the hospital History and Physical dated 1/13/15 revealed the resident had improvement with the diarrhea, although not entirely gone. The resident was hydrated over the course of 3 days and the hospital was aggressive with the potassium replacement. His/her potassium on dismissal was 4.2 mmol/L. The resident's magnesium was still low on 1/13/15 at 1.7 MG/DL this is within the normal limits (milligrams per deciliter) with a normal value of magnesium 1.6 to 2.3 MG/DL and was started on supplemental magnesium. At the time of dismissal the resident's weight increased since he/she was no longer dehydrated with slowing of the diarrhea.

Review of the physician signed note dated

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1/23/15 the resident continued to have large loose bowel movement this morning. The resident finished the Methronidazole (an antibiotic used to treat gastro-intestinal infections). The physician ordered to continue the Acidophilus (a medication to help maintain gastrointestinal health) for two more weeks and then discontinue and also decrease the Simethecone (gas relieving medication) to four times a day and at bedtime.

Review of the resident's medical record revealed from the time the resident readmitted to the facility on 12/30/14 thru 2/3/15 facility failed to provide a nutritional assessment for his/her fluid needs.

Review of the bowel monitoring documentation for the month of December 2014 and January 2015 for resident #25's revealed the facility failed to document how many stools the resident had.

Review of the fluid intake from the resident's return from the hospital on 12/30/14 to 1/10/15 when he/she admitted to the hospital for dehydration revealed the resident's average fluid intake a day was 1480 cc (cubic centimeter).

Review of blood pressures taken between 12/30/14 and 1/10/15 revealed the resident's average blood pressure was 112/71 and inconsistently documented from the time the resident came back from the hospital and was admitted to the hospital for dehydration.

An observation on 1/29/15 at 2:55 p.m. revealed the resident was lying down on his/her bed resting. The resident showed no signs of distress or dehydration

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An interview on 1/29/15 at 2:53 p.m. with resident #25 revealed he/she continued to have loose stools. He/she reported the night nurse assisted him/her when he/she was unable to make it to the bathroom on time. Resident #25 revealed he/she continued to be worried about why he/she continued to have the diarrhea.

An interview on 2/2/15 at 9:13 a.m. with direct care staff E revealed the resident returned from the hospital in December of 2014 and he/she came back confused, incontinent, and using a walker. He/she also returned with diarrhea. The resident required assistance with his/her ADLs. The resident then went to the hospital for low potassium and dehydration. The diarrhea has continued for an extended period of time.

An interview on 2/2/15 at 3:27 p.m. with direct care staff F revealed the resident used the walker for ambulation along with cueing after his/her return from the hospital in December. The resident was admitted to the local hospital for an electrolyte problem in January. He/she also reported the resident had become lethargic and was falling. Staff F reported unless the resident used the call light staff was unaware of when or how much diarrhea the resident had due to being independent with toileting. Direct care staff F reported the only monitoring of hydration for the resident was at meal and snack times. He/she also reported the staff did not monitor the output for the resident.

Interview on 2/2/15 at 2:12 p.m. with licensed nursing staff G revealed the resident required a walker to ambulate and was independent with ADLs after returning from the hospital. Staff G

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reported the resident was incontinent of bowel when she came back from the hospital. The resident admitted to the hospital for low potassium and dehydration. The resident continued to have loose stools. He/she reported the facility did not monitor the output for the resident. Nurse G reported the resident's skin was intact with no redness; the staff did not assess his/her bowels, or skin turgor (the expected resiliency of the skin caused by the outward pressure of the cells and interstitial fluid) for dehydration after coming back from the hospital or the emergency visit on 1/3/15.

Interview on 2/2/15 at 3:41 p.m. with licensed nursing staff H reported the resident went to the behavioral unit and returned with diarrhea. Nurse H reported the resident became dehydrated and he/she requested the resident be seen by the physician. The resident's oxygen level was low at 85% room air. He/she was taken to the local hospital to the emergency room per the on-call physician orders. The resident was then brought back to the facility after his/her vitals were within normal limits and no lab work was drawn. The next day the resident was lethargic and required assistance with eating. On Friday January 9th the resident was taken back to the hospital and was admitted with a critically low potassium level of 2.4 mmol/L. The resident continued to have diarrhea and was incontinent of bowel.

Interview on 2/2/15 at 5:23 p.m. with dietary manager I reported he/she was unaware of the resident's change in condition or his/her new diagnosis of dehydration.

Interview on 2/2/15 at 6:04 p.m. with administrative nurse B revealed the facility failed

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to inform the dietary staff of the resident's new diagnosis of dehydration when he/she came back from the hospital, and nursing staff failed to monitor and assess the resident daily for signs and symptoms of dehydration. Nurse B also reported the facility failed to recognize the resident was at risk for dehydration after returning from the behavioral unit with the diarrhea first started.

Interview on 2/3/15 at 9:55 a.m. with physician D revealed the resident started the diarrhea when returning to the facility from the hospital. He/she reported the resident became dehydrated, had a low potassium level, and needed to be admitted to the hospital. He/she reported they expected the facility to be monitoring accurately the resident's fluid intake and output, along with daily assessments after returning with the new diagnoses for dehydration. He/she also expected the care plan to be updated and followed. Physician D continued that he/she expected the facility to be more aware of the resident's condition, monitor and assess him/her and communicate with him/her.

Review of the facility Water Policy and procedures dated 6/2013 revealed the policy was created to promote a healthier and higher quality of life for our residents, while preventing the incidence of dehydration. The targeted population included residents who had a decline in ADLs along with other risk factors or diarrhea. A schedule will be developed by the Director of Nursing/designee to coordinate focused rounds on the targeted population.

The facility failed to ensure resident #25 had sufficient fluid intake to maintain proper hydration

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F 327	Continued From page 20 and health after returning from the hospital with chronic diarrhea until the admitted to the hospital for treatment of dehydration and hypokalemia.	F 327		